BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SHERRY ANN PATRICK** **a.k.a. SHIRLEY PATRICK** **26 Gibbs Drive** **Phenix City, AL 36869** **Registered Nurse License No. 620785** RESPONDENT	Case No. 2013-104 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about August 8, 2012, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2013-104 against Sherry Ann Patrick aka Shirley Patrick (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about July 2, 2003, the Board of Registered Nursing (Board) issued Registered Nurse License No. 620785 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on August 31, 2012 and has not been renewed.

3. On or about August 8, 2012, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2013-104, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

26 Gibbs Drive

Phenix City, AL 36869.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about August 16, 2012, the signed Certified Mail Receipt was returned to our office indicating a delivery date of August 13, 2012.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service of the Accusation upon her, and therefore waived her right to a hearing on the merits of Accusation No. 2013-104.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated August 8, 2012, signed by Kami Pratab, finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2013-104 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes; Accusation No. 2013-104, Statement to Respondent, Notice of Defense (two blank copies), Request for Discovery and Discovery Statutes (Government Code sections 11507.5, 11507.6 and 11507.7), proof of service; and if applicable, mail receipt or copy of returned mail envelopes;

Exhibit 2: License History Certification for Sherry Ann Patrick aka Shirley Patrick, Registered Nurse License No. 620785;

Exhibit 3: Out of State Discipline (Washington Board of Nursing);

Exhibit 4: Affidavit of Katherine Arnautovic and Kami Pratab;

Exhibit 5: Certification of costs by Board for investigation and enforcement in Case No. 2013-104;

Exhibit 6: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2013-104.

The Board finds that the charges and allegations in Accusation No. 2013-104 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $8,860.75 as of October 9, 2012.

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DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Sherry Ann Patrick aka Shirley Patrick has subjected her following license(s) to discipline:

a. Registered Nurse License No. 620785

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

a. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Gross Negligence.

b. Violation of Business and Professions Code section 2761(a)(4) - Disciplinary action by another State Board of Nursing.

c. Violation of Business and Professions Code section 2762(a) - Obtaining or possessing controlled substances without a prescription.

d. Violation of Business and Professions Code section 2762(b) - Use of controlled substance or alcohol to an extent or in a manner dangerous or injurious to oneself and others.

e. Violation of Business and Professions Code section 2762(e) - Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to a controlled substance.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 620785, heretofore issued to Respondent Sherry Ann Patrick aka Shirley Patrick, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on January 14, 2013

It is so ORDERED December 14, 2012

Board of Registered Nursing
Department of Consumer Affairs
State of California

Attachment:

Exhibit A: Accusation No. 2013-104

Exhibit A

Accusation No. 2013-104

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SHERRY ANN PATRICK, aka SHIRLEY PATRICK** **26 Gibbs Drive** **Phenix City, Alabama 36869** **Registered Nurse License No. 620785** Respondent.	Case No. 2013-104 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 2, 2003, the Board of Registered Nursing issued Registered Nurse License Number 620785 to Sherry Ann Patrick, aka Shirley Patrick (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on August 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY/REGULATORY PROVISIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

7. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

...

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. California Code of Regulations, title 16, section 1444, subsection (c) states, in pertinent part, that an act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such acts shall include dishonesty, fraud, or deceit.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. Hydromorphone (brand name "Dilaudid") is used to relieve moderate to severe pain. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, and a dangerous drug under Code section 4022.

11. Morphine Sulfate (brand name "MS Contin") is a highly addictive narcotic that acts directly on the central nervous system to relieve pain. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, and a dangerous drug under Code section 4022.

12. Marijuana is a hallucinogenic drug derived from the hemp plant. It is a Schedule I controlled substance as designated by Health and Safety Code section 11054, subdivision (d)(13), and a dangerous drug under Code section 4022.

13. Pyxis is a computerized management, storage, and medication dispensing system/machine. It is a medication cart/unit containing all medications used throughout a hospital. Each Pyxis is linked to the main computer maintained by the Hospital's Pharmacy Department where all Pyxis information is stored. Medical staff are given access to the Pyxis via an assigned pass word selected by each medical employee.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Out of State Discipline)

14. Respondent has subjected her license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about November 1, 2011, in a disciplinary action before the Nursing Care Quality Assurance Commission ("NCQAC") for the State of Washington, Department of Health, the NCQAC suspended Respondent's registered nurse license for 24 months. The circumstances of the suspension are that on or about August 1, 2009, through December 3, 2009, while employed as a registered nurse at St. Joseph Hospital in Bellingham, Washington, Respondent made eight grossly incorrect, or grossly inconsistent entries in seven hospital patient records, pertaining to Hydromorphone.

SECOND CAUSE FOR DISCIPLINE

(Grossly Incorrect and/or Grossly Inconsistent Entries in Patient Records)

15. Respondent has subjected her license to disciplinary action under Code section 2761, subdivision (a) on the grounds of unprofessional conduct, as defined in section 2762, subdivision (e), in that on or about October 19, 2010 through November 12, 2010, while employed as a travel registered nurse under contract with Med Staff on the Telemetry unit at NorthBay

HealthCare/Vaca Valley Campus, Vacaville, California, Respondent made grossly incorrect, or grossly inconsistent entries in hospital and patient records pertaining to a controlled substance and/or dangerous drug in the following respects:

A. Patient 1[1]

1. On November 1, 2010, at 12:32 a.m., Respondent withdrew from Pyxis 2 mg of Morphine for patient 1. Respondent failed to document the administration of Morphine to patient 1 or otherwise account for the wastage of 2 mg of Morphine.

2. On November 1, 2010, at 3:19 a.m., Respondent withdrew from Pyxis 2 mg of Morphine for patient 1. Respondent failed to document the administration of Morphine to patient 1 or otherwise account for the wastage of 2 mg of Morphine.

B. Patient 2

1. On October 23, 2010, at 12:05 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 2. The physician's order was for 1 mg of Dilaudid every two hours, as needed for moderate pain. Respondent administered 1 mg of Dilaudid to patient 2 at 12:20 a.m. Respondent did not document failed to document the administration or otherwise account for the wastage of the remaining 1 mg of Dilaudid.

2. On October 23, 2010, at 12:59 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 2. Respondent administered 1 mg of Dilaudid to patient 2 at 2:04 a.m. Respondent did not document failed to document the administration or otherwise account for the wastage of the remaining 1 mg of Dilaudid.

C. Patient 3

1. On November 9, 2010, at 11:40 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 3. The physician's order was for .5 mg of Dilaudid every two hours, as needed for moderate pain. Respondent administered 2 mg of Dilaudid to patient 2 at 11:45 p.m. Respondent administered 1.5 mg of Dilaudid in excess of physician's orders to patient 3.

[1] The patient names will be released to Respondent pursuant to a request for discovery.

D. Patient 4

1. On October 26, 2010, at 11:50 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 4, before there was a physician's order for Dilaudid. On October 27, 2010, at 1:33 a.m., Respondent documented the wastage of 2 mg of Dilaudid.

2. On October 27, 2010, at 3:04 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 4, before there was a physician's order for Dilaudid. Respondent documented the administration of 1 mg of Dilaudid to patient 4 at 3:10 a.m. Respondent administered 1 mg Dilaudid in excess of physician's order. On October 27, 2010, at 3:21 p.m., Respondent documented the wastage of 1 mg of Dilaudid.

3. On October 27, 2010, at 4:09 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 4, before there was a physician's order for Dilaudid. Respondent documented the administration of 1 mg of Dilaudid to patient 4 at 4:10 a.m. Respondent administered 1 mg Dilaudid in excess of physician's order. Respondent documented the wastage of 1 mg of Dilaudid at 4:35 p.m.

4. On October 27, 2010, at 5:10 p.m., documented the administration of 1 mg of Dilaudid for patient 4, when there was no corresponding withdrawal of the Dilaudid from Pyxis. A physician's order for 1 mg of Dilaudid intravenous pyelogram was written at 5:00 a.m.

5. On October 27, 2010, at 6:36 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 4, in excess of physician's orders. Respondent documented the administration of 1 mg of Dilaudid to patient 4 at 7:03 p.m. Respondent failed to document or otherwise account for the administration or wastage of the remaining 1 mg of Dilaudid.

E. Patient 5

1. On October 27, 2010, at 11:35 p.m., Respondent withdrew from Pyxis 2 mg of Dialaudid for patient 5. On October 28, 2010, at 12:00 a.m., Respondent administered 1 mg of Dilaudid to patient 5. Respondent failed to document or otherwise account for the administration or wastage of the remaining 1 mg of Dilaudid.

2. On October 28, 2010, at 3:10 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 5, in excess of physician's orders. Respondent documented the

administration of .5 mg of Dilaudid to patient 5 at 3:10 a.m., and 1 mg of Dilaudid to patient 5 at 4:03 a.m. Respondent failed to document or otherwise account for the administration or wastage of the remaining .5 mg of Dilaudid.

3. On October 28, 2010, at 3:44 a.m., Respondent withdrew from Pyxis 4 mg of Morphine for patient 5. Respondent failed to document or otherwise account for the administration or wastage of the 4 mg of Morphine.

4. On October 28, 2010, at 6:53 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 5, in excess of physician's orders. Respondent documented the administration of .5 mg of Dilaudid to patient 5 at 7:15 a.m. The Pyxis machine reflects that Respondent wasted 1.5 mg of Dilaudid.

F. Patient 6

1. On October 29, 2010, at 11:13 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 6, when there was no physician's order for Dilaudid. Respondent failed to document or otherwise account for the administration or wastage of 2 mg of Dilaudid. The Pyxis report indicates that on October 30, 2010, at 5:36 a.m. Respondent wasted 2 mg of Dilaudid.

G. Patient 7

1. On October 28, 2010, at 5:53 a.m., Respondent withdrew from Pyxis 2 mg of Morphine for patient 7. Respondent failed to document or otherwise account for the administration or wastage of the 2 mg of Morphine.

H. Patient 8

1. On October 31, 2010, at 12:27 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 8. Respondent documented the administration of 1 mg of Dilaudid to patient 8 at 12:00 a.m., prior to the time the Dilaudid was actually withdrawn. Respondent failed to document or otherwise account for the administration or wastage of 1 mg of Dilaudid.

2. On October 31, 2010, at 1:39 a.m., Respondent withdrew from Pyxis 4 mg of Morphine for patient 8. Respondent failed to document or otherwise account for the administration or wastage of 4 mg of Morphine.

3. On October 31, 2010, at 4:16 a.m., Respondent documented in the Pyxis, the administration of 1 mg of Dilaudid to patient 8 and the wastage of 1 mg of Dilaudid. Respondent did not withdraw any Dilaudid from Pyxis for patient 8 during the above-referenced time frame. There is no corresponding documentation in the patient chart that 1 mg of Dilaudid was administered to patient 8.

4. On October 31, 2010, at 4:17 a.m., Respondent withdrew from Pyxis 4 mg of Morphine for patient 8. Respondent documented the administration of 4 mg of Morphine to patient 8 at 4:20 a.m. Respondent previously documented the administration of 4 mg of Morphine to patient 8 at 1:39 a.m. The physician's order was for the administration of 4 mg of Morphine every four hours. Respondent failed to comply with the physician's order in that she administered the Morphine too early.

5. On October 31, 2010, at 6:20 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 8. Respondent documented the administration of 2 mg of Dilaudid to patient 8 at 6:10 a.m., before the Dilaudid was withdrawn from Pyxis.

I. Patient 9

1. On October 21, 2010, at 11:29 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 9, in excess of physician's order. Respondent documented the administration of 1 mg to patient 9 at 11:30. Respondent failed to document or otherwise account for the administration or wastage of 1 mg of Dilaudid.

2. On November 4, 2011, at 4:41 a.m., Respondent withdrew from Pyxis 1 mg of Dilaudid for patient 9. The Pyxis report indicates that Respondent documented the administration of 1 mg of Dilaudid to patient 9 and the wastage of 1 mg of Dilaudid at 6:52 a.m. The Pyxis report indicates that Respondent documented more Dilaudid than was actually removed. Respondent failed to document the administration of 1 mg of Dilaudid to patient 9, in the patient chart.

J. Patient 10

1. On November 6, 2010, at 12:54 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 10. The patient had a physician's order for 2 mg of Dilaudid every two

hours, as needed for moderate pain. Respondent documented the administration of 2 mg of Dilaudid to patient 10 at 1:00 a.m. Respondent failed to comply with the physician's order in that she administered the Dilaudid too early.

2. On November 6, 2010, at 2:36 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 10. Respondent documented the administration of 2 mg of Dilaudid to patient 10 at 2:40 a.m. Respondent previously documented the administration of 2 mg of Dilaudid to patient 10 at 1:00 a.m. Respondent failed to comply with the physician's order in that she administered the Dilaudid too early.

3. On November 6, 2010, at 4:34 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 10. Respondent documented the administration of 2 mg of Dilaudid to patient 10 at 4:30 a.m., before the Dilaudid was withdrawn from Pyxis. Respondent previously documented the administration of 2 mg of Dilaudid to patient 10 at 2:40 a.m. Respondent failed to comply with the physician's order in that she administered the Dilaudid too early.

4. On November 6, 2010, at 5:40 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 10. Respondent documented the administration of 2 mg of Dilaudid to patient 10 at 6:08 a.m. Respondent previously documented the administration of 2 mg of Dilaudid to patient 10 at 4:30 a.m. Respondent failed to comply with the physician's order in that she administered the Dilaudid too early.

K. Patient 11

1. Patient 11 did not have a physician's order for Dilaudid. On November 4, 2010, at 11:15 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 11. Respondent documented the administration of 2 mg of Dilaudid to patient 11 at 11:15 p.m.

2. Patient 11 did not have a physician's order for Dilaudid. On November 5, 2010, at 12:36 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 11. Respondent documented the administration of 2 mg of Dilaudid to patient 11 at 12:40 a.m.

3. Patient 11 did not have a physician's order for Dilaudid. On November 5, 2010, at 2:25 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 11. Respondent documented the administration of 2 mg of Dilaudid to patient 11 at 2:30 a.m.

4. Patient 11 did not have a physician's order for Dilaudid. On November 5, 2010, at 5:59 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 11. Respondent documented the administration of 2 mg of Dilaudid to patient 11 at 6:00 a.m.

5. Patient 11 did not have a physician's order for Dilaudid. On November 5, 2010, at 7:04 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 11. Respondent documented the administration of 2 mg of Dilaudid to patient 11 at 7:10 a.m.

L. Patient 12

1. Patient 12 did not have a physician's order for Dilaudid. On October 26, 2010, at 11:15 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 12. Respondent failed to document or otherwise account for the administration or wastage of 2 mg of Dilaudid.

2. On October 27, 2010, at 3:02 a.m., Respondent withdrew from Pyxis 4 mg of Morphine for patient 12. Respondent failed to document or otherwise account for the administration or wastage of 4 mg of Morphine.

3. On October 27, 2010, at 7:10 a.m., Respondent withdrew from Pyxis a 30 mg syringe of Morphine for patient 12. Respondent documented the administration of 30 mg of Morphine to patient 12 at 6:00 a.m., before the Morphine was withdrawn from Pyxis.

M. Patient 13

1. On November 4, 2010, at 1:17 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient 13. Respondent documented the administration of 2 mg of Dilaudid to patient 13 at 1:47 a.m. Respondent also documented the administration of 2 mg of Dilaudid to patient 13 at 1:49, without having made a corresponding withdrawal of Dilaudid from Pyxis.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence)

16. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a)(1) on the grounds of gross negligence based on the acts and/or omissions set forth in about paragraph 15, above.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

17. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) on the grounds of incompetence based on the acts and/or omissions set forth in paragraph 15, above.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Unlawfully Obtained Controlled Substance)

18. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (a), because she unlawfully obtained controlled substances. The circumstances are described above in paragraph 15.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Unlawfully Used Controlled Substance/Alcohol)

19. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (b), because she admitted abusing Marijuana, Alcohol, and Dilaudid.

DISCIPLINE CONSIDERATIONS

20. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 18, 2010, in a prior action, the Board of Registered Nursing issued Citation Number 2010-1207 and ordered Respondent to pay a fine in the amount of $2,500.00. The circumstances of the Citation are that on or about February 1, 2010, while employed as a registered nurse at Desert Regional Medical Center, Respondent presented an Advanced Cardiac Life Support ("ACLS") card issued from Twin Cities Community Hospital, with an expiration date of August 30, 2011. An investigation revealed that the ACLS card was fraudulent, in that the card issued from Twin Cities Community Hospital expired in 2008. That Citation is incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 620785, issued to Sherry Ann Patrick, aka Shirley Patrick.

2. Ordering Sherry Ann Patrick, aka Shirley Patrick to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: August 8, 2012

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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